PRE-MEDICARE FACT SHEET*

The pre-Medicare (ages 55 – 64) suffer unique problems among the uninsured, not because they suffer from extremely high levels of uninsurance (about 10%), but because they are more likely to have multiple, and very serious, health conditions. In all age groups those without health insurance are less likely to seek preventive and routine care, and for the pre-Medicare foregoing such care can result in expensive and serious health conditions. The following table details coverage for the older population:

Health Insurance Status By Age Group and Type of Coverage

	Age Group in Years			
	50-54	**55-58**	**59-61**	**62-64**
Current Employer	73%	62%	53%	36%
Former Employer	6%	13%	20%	30%
Private/Nongroup	6%	6%	9%	12%
Public	6%	8%	9%	12%
Uninsured	9%	11%	9%	10%

U.S. Census Bureau. (2000). Current Population Survey. Washington D.C.: U.S. Census Bureau.

Demographics of the Uninsured, Ages 55 to 64, 1998

Race is a major contributing factor to an analysis of the uninsured population in the US. Thirty-one percent of pre-Medicare Hispanics are uninsured, while 15% of Blacks and only 8% of Whites are uninsured in this age group.

Education plays a large role in who is uninsured. Twenty-three percent of those with no high-school diploma are uninsured for ages 55-64, while only 7% are uninsured who have a high-school diploma.

Income relative to poverty is an important factor. Twenty-six% are uninsured at income levels less than 200% FPL, while only 5% are uninsured at income levels of more than 200% FPL.

Health plays an important part in insurance coverage. With excellent health only 8% in this age group are uninsured, while the percentages rise to 10% and 15% for good, and fair to poor health, respectively.

Health Insurance Options for the Pre-Medicare

Employer Sponsored and Retirement Health Insurance (RHI) Benefit Options:

Many people have retired by the time they reach the early 60s; 85% of men are working at ages 50-54, but only 48% continue to work by ages 62-64. The numbers for women show a similar drop from 71% working at ages 50-54 and only 36% remaining in the work force at ages 62-64.

Access to RHI varies by gender and wage. For ages 50-54 thirty-seven percent of men have access to own (or spouse) RHI while for the same age group only 34% of women have similar access. Low-income individuals are less likely to have access to own employer offerings for RHI. For those with wages less than $10 per hour only 23% have access, and for wages 0-20, and greater than $20 per hour, access was 38% and 45%, respectively.

Cost of employer offered HRI, if offered, is higher than equivalent coverage for active employees. Large firms that paid health insurance premiums paid an average of 77% for active workers and only 52% for retired workers (if they offered HRI at all).

HRI is expensive. One in ten of the retired workers offered RHI refuse because they consider it too costly.

COBRA regulations and cost can be prohibitive. Only employers with 20 or more employees must provide COBRA continuation coverage, and that is only for a period of 18 months (29 months for a disabled worker). Since former workers assume 102% of the employer's group rate costs premiums are high (implies low take-up rates). According to the Urban Institute's estimates only 2% of them have COBRA coverage.

Given the limited availability of RHI, the high cost of COBRA and RHI, and the limited duration of COBRA *the pre-Medicare are significantly less likely than younger adults to have employer-sponsored coverage.*

Public Sources: To qualify for Medicaid non-elderly can only qualify by passing income and asset tests and being blind or disabled. To qualify for Medicare individuals must be blind or disabled and benefits will not begin for 29 months after the beginning of the disability or blindness.

The Private, Nongroup Market: Pooling is more limited for nongroup coverage thereby driving premium costs up. Administrative costs are higher for nongroup coverage. Employer subsidies are usually not available for nongroup coverage. Nongroup coverage is less affordable. (*In 1994 annual nongroup premium costs were about $2100, while those with employer-sponsored coverage paid out of pocket just under $900.*

Premiums increase with the number of health conditions. Private nongroup coverage average monthly premiums for ages 62-64 in 1998 were $337 for no health condition, and $523 and $693 for one, and two or more conditions, respectively.

The poor pay more. For those with income level less than 100% FPL average premiums are $523 per month, average. For income levels from 100% FPL to 400$ FPL average premiums are approximately $440 per month.

Limited benefits are the norm in the private nongroup market. Because of high costs many individuals opt for limited coverage, high deductible, high co-pay policies.

Insurers are afraid to offer comprehensive coverage, low deductible policies to the pre-Medicare because of the risk of adverse selection. This adverse selection problem drives up premium costs and forces better risks out of the private market and is thusly destabilizing for the private nongroup market.

Pre-existing conditions cause many individuals to be denied private market insurance even if they could afford the coverage.

Employer Sponsored Insurance (ESI) coverage declines from the early 50s (for 50-54 some 74% report coverage from current employers, dropping to 36% for ages 62-64).

Public Insurance Coverage rises from ages 50-54 at 6% to 12% in the 62-64 year age group.

Outlook for Coverage of the Pre-Medicare in the Future

RHI coverage seems to be declining. *Between 1991 and 1998…the prevalence of retiree health benefits sponsored by large employers fell from 80 percent to 67 percent. When these workers retire in upcoming years, fewer of them will be able to rely upon employer-sponsored coverage than the current generation of pre-Medicare retiree.*

Contributions to RHI costs are increasing to the pre-Medicare (cost shifting). Ninety-one percent of participants were required to contribute some portion of their RHI in 1995 versus 35% contributing in 1985. Higher levels of contributions may cause more declines in RHI among the pre-Medicare.

Other cost cutting measures being used by firms include: tighter eligibility requirements, caps *that employers could face for their RHI plans,* potential caps on future obligations by employers for RHI plans, and *the substitution of indemnity plans with managed care plans.*

Health benefits and RHI plans do not vest. Employers can decide drop, or reduce, contributions to RHI plans at any time. Workers seem more likely to stay in the work force and delay retirement if there are no RHI benefits from their employer. This can have serious ramifications on someone with a major health condition.

Policy Issues

Issues are similar to those confronting policy issues for young adults.

For many persons ages 55 to 64 the lack of health insurance results from their limited incomes.
For other pre-Medicare persons, the lack of adequate insurance coverage is related to their age and to health problems.
Benefits may be lost at retirement.

Comprehensive health insurance is expensive, difficult to purchase, subject to pre-existing conditions and large premium increases.
Health status is subject to rapid deterioration and expensive treatment.

Expansion of tax credits as an option: May have very limited effect on the pre-Medicare. *Reducing the after-tax premium cost to individuals will not resolve the problems of adverse selection, denials of coverage, and pre-existing condition exclusions that confront many pre-Medicare Americans in the private nongroup market.*

Medicare buy-in plan allowing individuals to purchase Medicare coverage at ages below full eligibility has been proposed as a possibility. This option would not rely on the non-group, private sector market. A forthcoming study *from the Kaiser Family Foundation indicates that a cost-neutral buy-in plan would not substantially increase coverage rates.* Estimates suggest that this kind of buy-in would have high premiums so a subsidy might be needed to substantially increase coverage for the pre-Medicare, or for the low-income.

Source:

Johnson, R. (2001, March 13). Gaps in Health Insurance Coverage Among the Near Elderly. Urban Institute. [On-Line]. Available HTTP: http://www.urban.org/TESTIMONY?johnson03-13-01.html [2001, June 14]

The Commonwealth Fund. (2000, July). Counting On Medicare: Perspectives and Concerns of Americans Ages 50 to 70. The Commonwealth Fund. [On-Line] Available HTTP: http://www.cmwf.org/programs/insurance/schoen%5F50to70%5Fbn%5F406.asp [2001, July 3]

The Henry J. Kaiser Family Foundation. (2000, December). Health Insurance Coverage in America 1999 Data Update. Washington D.C.: The Henry J. Kaiser Family Foundation.

U.S. Census Bureau. (2000). Current Population Survey. Washington D.C.: U.S. Census Bureau.